UNITED STATES FIRE INSURANCE COMPANY

Administrative Offices: 5 Christopher Way • 3rd Floor • Eatontown, NJ 07724

BLANKET BENEFITS - ACCIDENTS ONLY CERTIFICATE

This Certificate contains the terms under which the United States Fire Insurance Company agrees to insure certain persons and pay benefits.

This Certificate is a part of, and is governed by, a Group Policy that has been issued in the state of CALIFORNIA and shall be governed by its laws.

Coverage under this Certificate is provided in consideration of payment of the initial premium, continued payment of premiums when due, and completion of an Application. This Certificate is a part of, and is governed by, a Group Policy. The Group Policy has been issued to, and is the contract between, the Group Policyholder and The United States Fire Insurance Company. The Group Policy is held by the Group Policyholder and may be inspected upon request at any reasonable time. The name of the Group Policyholder is shown in the Schedule.

This Certificate has been issued to you, the Certificateholder, as a Participant under the Group Policy, in accordance with the terms, conditions, and limitations of the Group Policy.

10 DAY RIGHT TO RETURN THIS CERTIFICATE: If for any reason, you are not satisfied with this Certificate, you may return it to us within 10-days after receiving it. Upon its return, we will refund any premium paid and this Certificate will be deemed void, just as though it had never been issued.

NOTICE

THIS NOTICE IS TO ADVISE YOU THAT SHOULD YOU HAVE ANY QUESTIONS OR COMPLAINTS REGARDING THIS CERTIFICATE, YOU MAY CONTACT UNITED STATES FIRE INSURANCE COMPANY AT 5 CHRISTOPHER WAY EATONTOWN, NEW JERSEY 07724 or CALL (732) 676-9800

ALSO AVAILABLE IS THE CONSUMER SERVICES DIVISION OF THE CALIFORNIA DEPARTMENT OF INSURANCE, WHICH MAY BE CONTACTED AS FOLLOWS: CALIFORNIA DEPARTMENT OF INSURANCE
CONSUMER SERVICES DIVISION; 300 SPRING STREET, SOUTH TOWER LOS ANGELES, CALIFORNIA 90013 or call 1-800-927-HELP or 1-800-927-4357

THE DEPARTMENT OF INSURANCE SHOULD BE CONTACTED ONLY AFTER DISCUSSIONS WITH THE INSURANCE COMPANY OR ITS REPRESENTATIVES HAVE FAILED TO PRODUCE A SATISFACTORY RESOLUTION TO THE PROBLEM.

Required Disclosure under California Insurance Code § 10270.3: Please note that all benefits payable under this Certificate may be subject to reduction, to the extent provided in this Certificate, to the extent that you are entitled to benefits, whether on an indemnity basis or on a provision-of-service basis, for hospital, medical, dental, or surgical expenses under any other valid and collectible individual, group, or blanket insurance policy or contract, hospital or medical service program, or group-practice prepayment plan, except for automobile medical payments insurance.

THIS IS ACCIDENT ONLY COVERAGE. READ IT CAREFULLY.

BENEFITS ARE NOT PAYABLE FOR LOSS DUE TO SICKNESS.

THIS CERTIFICATE PAYS BENEFITS FOR SPECIFIC LOSSES FROM ACCIDENTS ONLY.

THIS CERTIFICATE IS NOT RENEWABLE.

Signed for **The United States Fire Insurance Company** By:

Signature

Marc J. Adee
Chairman and CEO

Signature

James Kraus
Secretary

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The following provisions appear within this Certificate in the following order:

SCHEDULE OF BENEFITS

COVERAGE IS PROVIDED UNDER GROUP POLICY NUMBER: AH-GA26932-002

ISSUED TO GROUP POLICYHOLDER: The Group and Blanket Accident & Health Insurance Trust

CERTIFICATEHOLDER:	San Pedro Property Owner Alliance
CERTIFICATE NUMBER:	US963842
CERTIFICATE EFFECTIVE DATE:	Sep 15, 2017
CERTIFICATE EXPIRATION DATE:	Nov 01, 2017

CLASSES OF ELIGIBLE PERSONS:

A person may be covered only under one Class of Eligible Persons even though He or She may be eligible under more than one class.

See Application

HAZARDS INSURED AGAINST:

Class	Hazard #	Description of Hazard
See Application		Policyholder Functions

BENEFIT PERIOD:	Provided treatment begins within 30 days from the date of Injury, Benefits are payable for 52 weeks from the date of an Injury. The Injury must occur after the Effective Date and prior to the Expiration Date and care must be Medically Necessary.
DEDUCTIBLE AMOUNT:	See Below
COINSURANCE PERCENTAGE:	100% URC (Usual, Reasonable & Customary) Up to the Policy Maximum

MAXIMUM BENEFIT AMOUNT: **See Below**

MEDICAL EXPENSE BENEFIT

Hospital Room & Board Daily Maximum Benefit Amount:	URC
Intensive Care Room & Board Daily Maximum Benefit:	URC
Hospital Miscellaneous Maximum Benefit Amount:	URC
Outpatient Pre-Admission Testing Benefit Amount:	URC
Outpatient Hospital Emergency Room Treatment Maximum Benefit Amount:	URC
Surgical Benefits:	
Primary Surgeons Maximum Benefit Amount:	URC
Assistant Surgeon, Second Surgical Opinion, Consultation Maximum Benefit:	URC
Anesthesia Maximum Benefit:	URC
Surgical Facility Maximum Benefit per Operating Session:	URC

Doctor's Visits	
In-Hospital Maximum Benefit:	URC
Office Visits Maximum Benefit:	URC
Maximum for All In-Hospital and Office Doctor's Visits:	URC
X-ray and Laboratory Maximum Benefit Amount:	URC
Nursing Maximum Benefit Amount:	URC
Physiotherapy Benefit	
Maximum Benefit Amount (Hospital Inpatient):	URC
Maximum Benefit Amount (Outpatient):	URC
Maximum for All Physiotherapy Combined (Inpatient & Outpatient):	URC
Ambulance Maximum Benefit Amount:	URC
Medical Equipment Rental Charges Maximum Benefit Amount:	URC
Medical Services and Supplies Maximum Benefit Amount (Blood, Blood Transfusions, Oxygen):	URC
Dental Treatment For Injury Only	
Maximum Benefit Amount:	See Below
Out-Patient Prescription Drug Benefit	
Maximum Benefit Amount:	URC
Accidental Death, Dismemberment, Loss of Sight, Speech, Hearing, Or Paralysis	
Principal Sum:	See Below
Aggregate Limit per Accident for AD&D only	See Below

Class I:	All active spectators and/or ticketholders who are attending an Insured Group's sponsored, scheduled and supervised short-term event, for whom premium has been paid.
Option 1 Limits:	$5,000 Accidental Death & Accidental Dismemberment Benefit $5,000 Accident Medical Expense Benefit (Excess Basis) $100 Corridor Deductible (per incident per person) $250 Dental Maximum (per Tooth per Accident) $50,000 Aggregate Limit per Accident for AD&D only

DEFINITIONS

The terms shown below shall have the meaning given in this section whenever they appear in this Certificate. Additional terms may be defined within the provision to which they apply.

"Accident" means a sudden, unforeseeable external event which causes Injury to one or more Covered Persons.

"Benefit Period" means the period of time from the date of Injury, as shown in the Schedule of Benefits.

"Covered Person" means an Insured Person eligible for coverage as identified in the Enrollment/Application][who is a U.S citizen residing in the United States, or if not a U.S. citizen, resides permanently in the United States],for whom proper premium payment has been made when due, and who is therefore insured under the Policy and this Certificate.

"Deductible" means the amount of Eligible Expenses which must be paid by the Covered Person before benefits are payable under this Certificate. It applies separately to each Covered Person.

"Eligible Expenses" means the Usual, Reasonable and Customary charges for services or supplies which are incurred by the Covered Person for the Medically Necessary treatment of an Injury. Eligible Expenses must be incurred while this Certificate is in force.

"He", "his" and "him" includes "she", "her" and "hers."

"Health Care Plan" means any contract, policy or other arrangement for benefits or services for medical or dental care or treatment under:
(1) Group or blanket insurance, whether on an insured or self-funded basis;
(2) Hospital or medical service organizations on a group basis;
(3) Health Maintenance Organizations on a group basis.
(4) Group labor management plans;
(5) Employee benefit organization plan;
(6) Professional association plans on a group basis; or
(7) Any other group employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974 as amended.

"Hospital" means an institution which:
(1) Is operated pursuant to law;
(2) Is primarily and continuously engaged in providing medical care and treatment to sick and injured persons on an inpatient basis;
(3) Is under the supervision of a staff of Physicians;
(4) Provides 24-hour nursing service by or under the supervision of a graduate registered nurse, (R.N.);
(5) Has medical, diagnostic and treatment facilities, with major surgical facilities;
    (a) On its premises; or
    (b) Available to it on a prearranged basis; and
(6) Charges for its services.

"Hospital" does not include:
(1) A clinic or facility for:
    (a) Convalescent, custodial, educational or nursing care;
    (b) The aged, drug addicts or alcoholics; or
    (c) Rehabilitation; or
(2) A military or veterans hospital or a hospital contracted for or operated by a national government or its agency unless:
    (a) The services are rendered on an emergency basis; and
    (b) A legal liability exists for the charges made to the individual for the services given in the absence of insurance.

"Hospital Stay" means a Medically Necessary overnight confinement in a Hospital when room and board and general nursing care are provided for which a per diem charge is made by the Hospital.

"Injury" means bodily harm of which an Accident is the proximate cause. All injuries to the same Covered Person sustained in one accident, including all related conditions and recurring symptoms of the Injuries will be considered one Injury.

"**Medically Necessary" or "Medical Necessity"** means a treatment, service or supply that is:
(1) required to treat an Injury;
(2) prescribed or ordered by a Physician or furnished by a Hospital;
(3) performed in a setting required by the condition;
(4) consistent with the medical and surgical practices prevailing in the area for treatment of the condition at the time rendered.

The purchasing or renting air conditioners; air purifiers, motorized transportation equipment, escalators or elevators in private homes, swimming pools or supplies for them; and general exercise equipment are not considered Medically Necessary.

The fact that a Physician may prescribe, authorize, or direct a service does not of itself make it Medically Necessary or covered by the Group Policy.

"Nurse" means either a professional, licensed, graduate registered nurse (R.N.) or a professional, licensed practical nurse (L.P.N.).

"Physician" means a person who is a doctor of medicine, osteopathy, psychology or other legally qualified practitioner of a healing art that is required by law to be licensed and is acting within the scope of his/her license under the laws in the state in which he/she practices and providing only those medical services which are within the scope of his/her license or certificate. It does not include an Insured, an Insured's Spouse, Domestic Partner, son, daughter, father, mother, brother or sister or other relative;

"Supervised or Sponsored Activity" means a Certificateholder or School authorized function:
(1) In which the Covered Person participates;
(2) Which is organized by or under its auspices;
which is within the scope of customary activities for such entity and is shown on the Schedule of Benefits.

"Usual, Reasonable and Customary means the amount that is the normal payment range for a specific medical procedure performed within a given geographic area. If the charges submitted are higher than what is considered normal for the covered services, then We may not allow the full amount charged.

SCOPE OF COVERAGE

We will provide the benefits described in this Certificate to all Covered Persons who suffer a covered loss which:
(1) Is within the scope of the **DESCRIPTION OF BENEFITS PROVISIONS** and is the proximate result of disease or bodily infirmity, from an Injury which is suffered in an Accident;
(2) Occurs while the person is a Covered Person under this Certificate; and
(3) Is within the scope of the risks set forth in the **DESCRIPTION OF HAZARDS** provisions.

Full Excess Medical Expense:
If an Injury to the Covered Person results in his incurring Eligible Expenses for any of the services in the SCHEDULE OF BENEFITS, we will pay the Eligible Expenses incurred, subject to the Deductible Amount and Coinsurance Percentage (if any), that are in excess of Expenses payable by any other Health Care Plan, regardless of any Coordination of Benefits provision contained in such Health Care Plan.

The Covered Person must be under the care of a Physician when the Eligible Expenses are incurred. The Expense must be incurred solely for the treatment of a covered Injury:
(1) While the person is insured under this Certificate; or
(2) During the Benefit Period stated on the SCHEDULE OF BENEFITS.

The first Expense must be incurred within the time frame shown on the SCHEDULE OF BENEFITS.

The total of all medical benefits payable under this Certificate is shown on the SCHEDULE OF BENEFITS: and
(1) Subject to the specific maximums shown on the SCHEDULE OF BENEFITS; and
(2) Subject to compliance with the requirement, set forth in the Limitations section of this Certificate.

PROVISIONS CONCERNING COVERED PERSONS

Eligibility:
Persons eligible to be insured under this Certificate are those persons described as an ELIGIBLE CLASS on the Application. This includes anyone who may become eligible while this Certificate is in force.

Effective Dates:
A Covered Person will become an insured under this Certificate, provided proper premium payment is made, on the latest of:
(1) The Effective Date of this Certificate; or
(2) The day he becomes eligible according to the referenced date shown in the Application.

Termination:
Insurance for a Covered Person will end on the earliest of:
(1) The date he is no longer in an Eligible Class.
(2) The date he reports for active duty in any Armed Forces, according to the referenced date shown in the Application. We will refund, upon receipt of proof of service, any premium paid, calculated from the date active duty begins until the earlier of:
    (a) The date the premium is fully earned; or
    (b) The Expiration Date of this Certificate.
    This does not include Reserve or National Guard duty for training;
(3) The end of the period for which the last premium contribution is made; or
(4) The date the Group Policy is terminated.

DESCRIPTION OF HAZARDS

HAZARD: POLICYHOLDER FUNCTIONS

Subject to all other provisions of this Certificate, coverage is provided for a Covered Person while he is:

(1) Attending or participating in a Supervised or Sponsored Activity; or
(2) Attending a Policyholder function.

The activity has to be an event or activity sponsored by and part of the operations of the policyholder.

The Covered Person must be:
(1) On the premises of the Policyholder:
    (a) During its normal hours;
    (b) During scheduled functions; or
    (c) During other periods if he is attending or participating in a Supervised or Sponsored Activity;
(2) Not on Policyholder: premises and attending or participating in a Supervised or Sponsored Activity;
(3) Traveling directly, without interruption:
    (a) Between his home and the Policyholder premises for participation in a Supervised or Sponsored Activity;
    (b) Between the site of the Supervised or Sponsored Activity and his home or the Policyholder: premises.
    (c) In a vehicle which is:
        (i) Designated or furnished by the Policyholder:;
        (ii) Operated by a properly licensed adult driver; and
        (iii) Under the direct supervision of the Policyholder; or
    (d) In a vehicle other than that described in (3)(c) when:
        (i) Operated by a properly licensed driver; and
        (ii) Travel time does not exceed an hour each way.

Travel time includes the time:

(i) To or from home, the Certificateholder's address and the Supervised or Sponsored Activity;
(ii) Before the appointed time; and
(iii) After the Supervised or Sponsored Activity is completed.

Unless otherwise stated, we will pay benefits for a covered loss, only once, even if coverage was provided under more than one Description of Hazards.

DESCRIPTION OF BENEFITS

BENEFIT A: BENEFITS FOR ACCIDENTAL DEATH, DISMEMBERMENT, LOSS OF SIGHT, SPEECH AND HEARING; OR PARALYSIS

If, within 1-year from the date of an Accident covered by this Certificate, Injury from such Accident, results in Loss listed below, we will pay the percentage of the Principal Sum set opposite the loss in the table below. If the Covered Person sustains more than one such Loss as the result of one Accident, we will pay only one amount, the largest to which he is entitled. This amount will not exceed the Principal Sum which applies for the Covered Person.

Loss	Percentage of Principal Sum
Loss of Life	100%
Loss of Both Hands	100%
Loss of Both Feet	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of One Hand and Entire Sight of One Eye	100%
Loss of One Foot and Entire Sight of One Eye	100%
Loss of Speech and Hearing (both ears)	100%
Quadriplegia (total Paralysis of both upper and lower limbs)	100%
Paraplegia (total Paralysis of both lower limbs	50%
Loss of One Hand	50%
Loss of One Foot	50%
Loss of Entire Sight of One Eye	50%
Loss of Speech	50%
Loss of Hearing (both ears)	50%
Hemiplegia (total Paralysis of upper and lower limbs on one side of body)	50%
Loss of Thumb and Index Finger of the Same Hand	25%

Loss of a hand or foot means complete Severance through or above the wrist or ankle joint.

Loss of sight means the total, permanent loss of sight of the eye. The loss of sight must be irrecoverable by natural, surgical or artificial means.

Loss of speech means total, permanent and irrecoverable loss of audible communication.

Loss of hearing means total and permanent loss of hearing in both ears which cannot be corrected by any means.

Loss of a thumb and index finger means complete Severance through or above the metacarpophalangeal joints (the joints between the fingers and the hand).

In California, loss of a thumb and index finger means loss by complete Severance of at least one whole phalanx of each.

"Severance" means the complete separation and dismemberment of the part from the body.

"Paralysis" means loss of use, without Severance, of a limb. This loss must be determined by a Physician to be complete and not reversible.

BENEFIT - MEDICAL EXPENSE

We will pay, Eligible Expenses for a Covered Person's Injury, subject to the Deductible Amount and Coinsurance Percentage, if any, shown in the Schedule of Benefits. Eligible Expenses are those incurred for:

(1) **Hospital Room and Board** – charges for a semi-private daily room rate for each day of the Hospital Stay, up to the Maximum Daily Benefit Amount shown in the Schedule of Benefits for Hospital Room and Board.

(2) **Intensive Care Room and Board** - charges for each day of Intensive Care Unit confinement, up to the Daily Maximum Benefit Amount shown in the Schedule of Benefits for the Intensive Care Room and Board benefit. This payment is in lieu of payment for the Hospital Room and Board charges for those days.

(3) **Hospital Miscellaneous** - charges during a Hospital Stay, up to the Maximum Daily Benefit Amount shown in the Schedule of Benefits for the Hospital Miscellaneous benefit. Miscellaneous charges do not include charges for telephone, radio or television, extra beds or cots, meals for guests, take home items, or other convenience items.

(4) **Outpatient Hospital Expenses** - charges by a Hospital for:
(a) Pre-admission testing (confinement must occur within 7 days of the testing); or
(b) Emergency room treatment, up to the Maximum Benefit Amount per emergency shown in the Schedule of Benefits for the Outpatient Emergency Room Treatment benefit.

(5) **Surgical Benefits** - charges for:
(a) A Physician, for primary performance of a surgical procedure, up to the Maximum Benefit Amount shown in the Schedule of Benefits per procedure. Two or more surgical procedures through the same incision will be considered as one procedure. However, we will pay up to 1.57 times the surgical procedure charge when more than one surgical procedure through different operating fields are performed during the same surgical session.
(b) A Physician, for: (i) assistant surgeon duties; (ii) a second surgical opinion; or (iii) consultation, up to the Maximum Benefit shown in the Schedule of Benefits for an Assistant Surgeon, Second Surgical Opinion, and Consultation.
(c) Anesthesia and its administration, up to the Maximum Benefit Amount shown in the Schedule of Benefits for the Anesthesia benefit.
(d) Use of surgical facilities, up to the Maximum Benefit Amount per operating session, as shown in the Schedule of Benefits for the Surgical Facility benefit.

(6) **Physician's Visits** - charges by a Physician for other than pre- or post-operative care:
(a) For in-Hospital visits, up to the Maximum Benefit Amount shown in the Schedule of Benefits for Physician's Visit – In-Hospital.
(b) For office visits, up to the Maximum Benefit Amount shown in the Schedule of Benefits for Physician's Office Visits.
Total visits per Injury will not exceed the combined Maximum shown in the Schedule of Benefits for All In-Hospital and Office Physician's Visits.

(7) **X-Ray and Laboratory** - charges for X-ray and laboratory tests, up to the Maximum Benefit Amount shown in the Schedule of Benefits for the X-ray & Laboratory benefit.

(8) **Nursing Services** - Charges for nursing services (other than routine Hospital care) by or under the supervision of a licensed graduate registered nurse, up to the Maximum Benefit Amount shown on the Schedule of Benefits for the Nursing benefit.

(9) **Physiotherapy -** Charges for physiotherapy:
(a) While Hospital confined, up to the Maximum Benefit Amount shown in the Schedule of Benefits for the Hospital Inpatient Physiotherapy benefit;
(b) As an outpatient, up to the Maximum Benefit Amount shown on the Schedule of Benefits for the Outpatient Physiotherapy benefit.

Physiotherapy includes:

(a) Heat treatment;
(b) Diathermy;
(c) Microtherm;
(d) Ultrasonic;
(e) Adjustment;
(f) Manipulation;
(g) Massage therapy and
(h) Acupuncture.

Total treatment per Injury will not exceed the Maximum Benefit Amounts for Physiotherapy shown in the Schedule of Benefits.

(10) **Ambulance** - from the place where the Injury occurred to the Hospital, up to the Maximum Benefit Amount shown in the Schedule of Benefits for the Ambulance benefit.

(11) **Medical Equipment Rental** - charges for medical equipment for:
(a) A wheelchair;
(b) An iron lung; or
(c) Other medical equipment for which prior approval by us has been given;
up to the Maximum Benefit Amount shown in the Schedule of Benefits for the Medical Equipment Rental benefit.

(12) **Medical Services and Supplies** - Charges for medical services and supplies for:
(a) Oxygen and its administration;
(b) Blood and blood transfusions;
up to the Maximum Benefit Amount shown in the Schedule of Benefits for the Medical Service & Supply benefit.

(13) **Dental Treatment** - Charges for dental treatment for Injury to a tooth which was sound and natural at the time of Injury, up to the Maximum Benefit Amount shown in the Schedule of Benefits for the Dental Treatment benefit.

The amounts payable under this Medical Expense benefit could be greatly reduced if the Covered Person does not comply with the requirements in the Limitations section of this Certificate.

BENEFIT - OUT-PATIENT PRESCRIPTION DRUG BENEFIT

We will pay the Eligible Expenses, subject to the Deductible Amount and Coinsurance Percentage shown in the Schedule of Benefits, if any; for a Prescription Drug or medication when prescribed by a Physician on an outpatient basis.

Prescription Drug means a drug which:
(1) Under Federal law may only be dispensed by written prescription; and
(2) Is utilized for the specific purpose approved for general use by the Food and Drug Administration.

The Prescription Drug must be dispensed for the out-patient use by the Covered Person:
(1) On or after the Covered Person's Effective Date; and
(2) By a licensed pharmacy provider.

Benefits are payable up to the Maximum Benefit Amount shown on the Schedule of Benefits.

The amount payable under this benefit could be greatly reduced if the Covered Person does not comply with the requirements in the Limitations section of this Certificate.

EXCLUSIONS

Benefits will not be paid for a Covered Person's loss which:

(1) Is proximately caused by the Covered Person's own:
  (a) Intentionally self-inflicted Injury, suicide or any attempt thereat. (In Missouri this applies only while sane.);
  (b) Voluntary self-administration of any drug or chemical substance not prescribed by, and taken according to the directions of, a doctor (Accidental ingestion of a poisonous substance is not excluded.);
  (c) Commission or attempt to commit a felony;
  (d) Participation in a riot or insurrection;
  (e) [Injury caused by, contributed to or resulting from the Covered Person's use of alcohol, illegal drugs or medicines that are not taken in the dosage or for the purpose as prescribed by the Covered Person's Physician.

(2) Is proximately caused by:
  (a) Declared or undeclared war or act of war;
  (b) Aviation, except as specifically provided in this Certificate;
  (c) Sickness, disease, bodily or mental infirmity or medical or surgical treatment thereof, bacterial or viral infection, regardless of how contracted. This does not include bacterial infection that is the natural and foreseeable result of an accidental external bodily injury or accidental food poisoning.

ADDITIONAL EXCLUSIONS

Benefits will not be paid for:

1. Normal health checkups;
2. Dental care or treatment other than care of sound, natural teeth and gums required on account of Injury resulting from an Accident while the Covered Person is covered under this Certificate, and rendered within 6 months of the Accident;
3. Services or treatment rendered by a doctor, nurse or any other person who is:
   (a) Employed or retained by the Certificateholder; or
   (b) Who is the Covered Person or a member of his immediate family;
4. Charges which:
   (a) The Covered Person would not have to pay if he did not have insurance; or
   (b) Are in excess of Usual, Reasonable and Customary charges.
5. An Injury that is caused by flight in:
   (a) An aircraft, except as a fare-paying passenger;
   (b) A space craft or any craft designed for navigation above or beyond the earth's atmosphere; or
   (c) An ultra light, hang-gliding, parachuting or bungi-cord jumping;
6. Travel in or upon:
   (a) A snowmobile;
   (b) Any two or three wheeled motor vehicle;
   (c) Any off-road motorized vehicle not requiring licensing as a motor vehicle;
7. Any Accident where the Covered Person is the operator of a motor vehicle and does not possess a current and valid motor vehicle operator's license;
8. That part of medical expense arising out of a motor vehicle accident to the extent such benefits are payable by any automobile insurance Certificate without regard to fault. (Does not apply in any state where prohibited);
9. Injury that is:
   (a) The result of the Covered Person being Intoxicated. ("Intoxicated" will have the meaning determined by the laws in the jurisdiction of the geographical area where the loss occurs); or
   (b) Caused by any narcotic, drug, poison, gas or fumes voluntarily taken, administered, absorbed or inhaled, unless prescribed by a doctor;
10. Any Sickness, except infection which occurs directly from an Accidental cut or wound or diagnostic tests or treatment, or ingestion of contaminated food;
11. Blood or Blood plasma, except for charges by a Hospital for the processing or administration of blood;
12. Elective treatment or surgery, health treatment, or examination where no Injury is involved;
13. Injury sustained while in the service of the armed forces of any country. When the Covered Person enters the armed forces of any country, we will refund the unearned pro rata premium upon request;
14. Eyeglasses, contact lenses, hearing aids, braces, appliances, or examinations or prescriptions therefore;

15. Treatment in any Veterans Administration or Federal Hospital, except if there is a legal obligation to pay;
16. Treatment of temporomandibular joint (TMJ) disorders involving the installation of crowns, pontics, bridges or abutments, or the installation, maintenance or removal of orthodontic or occlusal appliances or equilibration therapy;
17. Cosmetic surgery, except for reconstructive surgery on a diseased or injured part of the body;
18. Benefits will not be provided for services or injuries or diseases related to your job to the extent you are covered or are required to be covered by the Workers' Compensation law. If you enter into a settlement giving up your right to recover future medical benefits under a Workers' Compensation law, this policy will not pay those medical benefits that would have been payable in absence of that settlement;
19. The repair or replacement of existing artificial limbs, orthopedic braces, or orthotic devices;
20. Rest cures or custodial care;
21. The repair or replacement of existing dentures, partial dentures, braces or fixed or removable bridges;
22. Expenses incurred for an Accident after the Benefit Period shown in the Schedule of Benefits;
23. Orthopedic appliances which are used mainly to protect an Injury so that a covered student can take part in interscholastic or intercollegiate sports;
24. Hernia of any kind; or any bacterial infection that was not caused by an Accidental cut or wound;
25. Prescription medicines unless specifically provided for under this Certificate.
26. Injuries, which result over a period of time (such as blisters, tennis elbow, etc.) are not covered.

LIMITATIONS

Any benefits payable under this Certificate will be limited to the following:

(1) The medical benefits otherwise payable under this Certificate will be reduced by 50% if:
   (a) Excess insurance is provided under this Certificate; and
   (b) The Covered Person has coverage under another plan providing medical expense benefits; and
   (c) The other plan is an HMO, PPO or similar arrangement ("PPO-Preferred Provider Organization" means an Organization offering health care services through designated health care providers who agree to perform these services at rates lower than nonpreferred providers.); and
   (d) The Covered Person does not use the facilities or services of the HMO, PPO or similar arrangement for the provision of benefits.

   The Covered Person's limitation does not apply to emergency treatment required within 24 hours after an Accident which occurred outside the geographic area serviced by the HMO, PPO or similar arrangement.

(2) Costs that exceed the Usual, Reasonable and Customary charges in the area where the services are furnished or supplies provided. Services, supplies and equipment must be:
   a) Medically necessary for the care or treatment of a covered Injury;
   b) Received while coverage is in force under this Certificate; and
   c) Rendered and/or prescribed by a licensed Physician other than the Covered Person (or a member of his household or immediate family) in accordance with current medical standards and practices.

(3) The application of the Coordination of Benefits or Non-Duplication of Benefits provision.

(4) If the Covered Person is admitted into the Hospital on a Friday or a Saturday on a non-emergency basis and the procedure for which he is admitted is not performed on the day of or the day after admission, we will not pay the Hospital charges for room and board or miscellaneous Hospital charges for the initial Friday or Saturday preceding the procedure.

MEDICAL REVIEW REQUIREMENTS

A Covered Person may request an independent medical review ("IMR") of disputed health care services from the California Department of Insurance if he or she believes that we have improperly denied, modified, or delayed health care services. A disputed health care service is any health care service eligible for coverage and payment under the Covered Person's coverage that has been denied, modified, or delayed by us, in whole or in part because the service is not Medically Necessary.

The IMR process is in addition to any other procedures or remedies that may be available. There is no application or processing fee of any kind for an IMR. The Covered Person has the right to provide information in support of the request for an IMR. We must provide the Covered Person with an IMR application form together with any grievance disposition letter that denies, modifies, or delays health care services. A decision not to participate in the IMR process may cause a Covered Person to forfeit any California statutory right to pursue legal action against us regarding the disputed health care service. It should be noted that we do not believe any such California statutory right exists which is applicable to it. For more information regarding the IMR process, or to request an application form, please contact us.

Eligibility. The California Department of Insurance will review the Covered Person's application for an IMR to confirm that:

1. a. The provider has recommended a health care service as Medically Necessary.

   b. The Covered Person has received urgent care or emergency services that a provider determined was Medically Necessary; or

   c. The Covered Person has been seen by a provider for the diagnosis or treatment of the medical condition for which he or she seeks independent review.

2. The disputed health care service has been denied, modified, or delayed by us based in whole or in part on a decision that the health care service is not Medically Necessary; and

3. The Covered Person filed a grievance with us and the disputed decision is upheld or the grievance remains unresolved after 30 days. If the grievance requires expedited review, the Covered Person may bring it immediately to the attention of the California Department of Insurance. It may waive the requirement that the Covered Person follow the *plan's* grievance process in extraordinary and compelling cases.

If a case is eligible for an IMR, the dispute will be submitted to a medical specialist who will make an independent determination as to whether or not the care is Medically Necessary. The Covered Person will receive a copy of the assessment made. If the IMR determines the service is Medically Necessary, we will provide benefits for the health care service.

For non-urgent cases, the IMR organization designated by the California Department of Insurance must provide its determination within 30 days of receipt of the Covered Person's application and supporting documents. For urgent cases involving an imminent and serious threat to a Covered Person's health, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of the Covered Person's health, the IMR organization must provide its determination within three business days.

PREMIUM PROVISIONS

GRACE PERIOD:

Unless not less than five days prior to the premium due date we have delivered to the Insured or have mailed to the Insured's last address as shown by our records written notice of our intention not to renew this Policy beyond the period for which the premium has been accepted, a grace period of 31 days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force (subject to the right of the insurer to cancel in accordance with the cancellation provision hereof).

PREMIUMS:
Premium due dates are the first of every month. Premium payment made in advance or for more than a one month period will not affect any provisions of this Certificate with regard to change. Failure by the Certificateholder to pay premiums within the grace period shall be deemed notice to us to terminate coverage at the end of the period for which premium was paid.

CHANGES IN RATES:
We have the right to change the premium rates on any premium due date:
(1) After the first 12 months insurance is in effect;
(2) Coinciding with a change in the coverage provided or classes eligible; or

(3) Coinciding with a change in the risks we have assumed.

We will give 31 days written notice of any change under (1) above. Notice will be sent to the Certificateholder's most recent address in our records.

GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES:
This Certificate, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by one of our executive officers and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Certificate or to waive any of its provisions.

All statements made by the Policyholder or by a Covered Person in the absence of fraud, be deemed a representation and not a warranty. No such statement shall (avoid the insurance or reduce the benefits under the Policy or) be used in defense to a claim hereunder unless it is contained in a written application, nor shall any such statement of the Policyholder or Covered Person, except a fraudulent misstatement, be used at all to void the Policy or this Certificate after it has been in force for three years from the date of its issue, nor shall any such statement of any person eligible for coverage under the Policy, except a fraudulent misstatement, be used at all in defense to a claim for loss incurred or disability (as defined in the policy) commencing after the insurance coverage with respect to which claim is made has been in effect for three years from the date it became effective.

WORKERS' COMPENSATION INSURANCE:
This Certificate is not in lieu of and does not affect any requirement for coverage under any Workers' Compensation Insurance.

CONFORMITY WITH STATE STATUTES:
Any provision of this Certificate in conflict, on the Effective Date of this Certificate, with the laws of the state where it is delivered, is amended to conform to the minimum requirements of such laws.

CLAIM PROVISIONS

NOTICE OF CLAIM:
Written notice of claim must be given to us within 20 days after the occurrence or commencement of any loss covered by this Certificate policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Insured or Covered Person to us at our administrative office listed on the cover-page of this Certificate, or to our authorized agent, with information sufficient to identify the Insured or Covered Person, shall be deemed notice to us.

CLAIM FORMS:
Upon our receipt of a notice of claim, we will furnish to the claimant such forms as are usually furnished by us for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this Certificate as to proof of loss upon submitting, within the time fixed in this Certificate for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

PROOF OF LOSS:
Written proof of loss must be furnished to us in the case of a claim for loss for which this Certificate provides periodic payment contingent upon continuing loss within 90 days after the end of the period for which we are liable. Written proof that the loss continues must be furnished to us at intervals required by us.

In case of claim for any other loss, proof must be furnished within 90 days after the date of such loss.

If that is not reasonably possible, we will not deny or reduce any claim if proof is furnished as soon as reasonably possible. Proof must, in any case, be furnished not more than a year later, except for lack of legal capacity.

TIME OF PAYMENT OF CLAIMS:
Benefits payable under this Certificate for any loss other than loss for which this Certificate provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid Monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

PAYMENT OF CLAIMS:
Benefits for a Covered Person's loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such benefit shall be payable to the estate of the Covered Person. Any other accrued benefits unpaid at the Covered Person's death may, at our option, be paid either to such beneficiary or to such estate. All other Benefits will be payable to the Covered Person.

If any benefits under this policy shall be payable to the estate of a Covered Person, or to a Cover Person or beneficiary who is a minor or otherwise not competent to give a valid release, we may pay such Benefit, up to an amount not exceeding $1,000, to any relative by blood or connection by marriage of the Covered Person or beneficiary who is deemed by us to be equitably entitled thereto. Any payment made by us in good faith pursuant to this provision shall fully discharge us to the extent of such payment.

Subject to any written direction of a Covered Person in the application or otherwise all or a portion of any benefits provided by this certificate on account of hospital, nursing, medical, or surgical services may, at our option and unless the Covered Person requests otherwise in writing not later than the time of filing proofs of that loss, be paid directly to the person or persons having paid for the hospitalization or medical or surgical aid, or to the hospital or person rendering those services; but it is not required that the service be rendered by a particular hospital or person.

PAYMENT OF CLAIMS: OTHER BENEFITS:
All other benefits will be paid to the Covered Person, if he is living, if not, we will pay his beneficiary or his estate.

PHYSICAL EXAMINATION:
We, at our own expense, shall have the right and opportunity to examine the person of the Covered Person when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

TIME LIMIT ON CERTAIN DEFENSES:
After the Policy has been in force for a period of three years, no statements of the Policyholder contained in the application, and no statement relating to insurability made by any Covered Persons eligible for coverage under the Policy shall be used to deny a claim or in contesting the validity of the insurance with respect to which such statement was made after the insurance has been in force prior to the contest for a period of three years during the lifetime of the person with respect to whom any such statement was made.

No claim for loss incurred after three years from the effective date of the insurance coverage with respect to which the claim is made shall be reduced or denied on the ground that a disease or physical condition, not excluded from coverage by name or specific description effective on the date of loss, had existed prior to the effective date of the coverage with respect to which the claim is made:

LEGAL ACTIONS:
No action at law or in equity shall be brought to recover benefits under this Certificate less than 60 days after written proof of loss has been furnished as required by this Certificate. No such action shall be brought more than 3 years after the time written proof of loss is required to be furnished.

California Guaranty Notice

NOTICE OF PROTECTION PROVIDED BY THE CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION

This notice provides a brief summary regarding the protection provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association). The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. Insurance Companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The valuable extra protection provided through the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and he amounts of coverage.

Below is a brief summary of the coverages, exclusions, and limit provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Association.

COVERAGE

- **Persons Covered**

Generally, an individual is covered by the California Life and Health Insurance Guarantee Association if the insurer was a member of the Association *and* the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

- **Amounts of Coverage**

The basic coverage protections provided by the Association are as follows:

Life Insurance, Annuities and Structured Settlement Annuity Benefits

For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

- **Life Insurance**

  80% of death benefits but not to exceed $300,000

  80% of cash surrender or withdrawal values but not to exceed $100,000

- **Annuities and Structured Settlement Annuities**

  80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed $250,000.

The maximum amount of protection provided by the Association to an individual, for *all* life insurance, annuities and structured settlement annuities is $300,000, regardless of the number of polices or contracts covering the individual.

- **Health Insurance**

The maximum amount of protection provided by the Association to an individual, as of April 1, 2011, is $470,125. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer.

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The California Life and Health Insurance Guarantee Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract;
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society;
- If the person is provided coverage by the guaranty association of another state;
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual;
- Employer and association plans, to the extent they are self-funded or uninsured;
- A policy or contract providing any health care benefits under Medicare Part C or Part D;
- An annuity issued by an organization that is only licensed to issue charitable gift annuities;
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract;
- Any policy of reinsurance unless an assumption certificate was issued;
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1607.02(b)(C)

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association please visit the Association's website at www.califega.org, or contact either of the following:

California Life and Health Insurance Guarantee Association
P.O. Box 16860
Beverly Hills, CA 90209-3319
(323) 782-0182

or

Consumer Service Division
California Department of Insurance
300 South Spring Street
Los Angeles, CA 90013
(800) 927-4357 or (213) 897-8921

Insurance companies and their agents are not allowed by California law to use the existence of the Guarantee Association or its coverage to solicit, induce or encourage you to purchase any form of insurance policy. When selecting an insurance company, you should not rely on Association coverage. If there is an inconsistency between this notice and California law, then California law will control.

When used throughout this document "Company", "Our", "We", or "Us" means:

☐ **United States Fire Insurance Company**

☐ **The North River Insurance Company**

GRIEVANCE PROCEDURES

When you submit a claim and that claim is denied, we will provide a written statement containing the reasons for the Adverse Determination. You have the right to request a review of any Company decision or action pertaining to our contractual relationship and to appeal any adverse claim determination we've made by filing a Grievance. These procedures have been developed to ensure a full investigation of a Grievance through a formal process.

DEFINITIONS

A **"Grievance"** is a written complaint requesting a change to a previous claim decision, claims payment, the handling or reimbursement of health care services, or other matters pertaining to your coverage and our contractual relationship.

An **"Adverse Determination"** is a determination by the Company or its designated utilization review organization that (i) a service, treatment, drug, or device, is experimental, investigational, specifically limited or excluded by your coverage; or (ii) a facility admission, the availability of care, continued stay or other health care services proposed or furnished have been reviewed and, based upon the information provided, does not meet the contractual requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness and therefore, the benefit coverage is denied, reduced or terminated in whole or in part.

INFORMAL GRIEVANCE PROCEDURE

You, your authorized representative, or a provider acting on your behalf may submit an oral complaint to us within 60-days after an event that causes a dispute. Telephoning allows you to discuss your complaint or concerns and gives us the opportunity to immediately resolve the problem.

If we don't have all the information necessary to review your complaint, we will request any additional information within 5 business days of receiving your complaint. After we receive all the necessary information, we will provide you, your authorized representative, or a provider acting on your behalf with our written decision within 30-days after receiving the complaint and all necessary information.

If the problem cannot be resolved in this manner, you still have the right to submit a written request for the complaint to be reviewed through the Formal Grievance Procedure, as outlined below.

FORMAL GRIEVANCE PROCEDURE

A formal Grievance may be submitted by you, your authorized representative, or in the event of an Adverse Determination, by a provider acting on your behalf.

If you file a formal Grievance, you will have the opportunity to submit written comments, documents, records and other information you feel are relevant to the Grievance, regardless of whether those materials were considered in the initial Adverse Determination.

First Level Review

Within 3 working business days after receiving the Grievance, we must acknowledge the Grievance and provide you, your authorized representative or a provider with the name, address, and telephone number of the coordinator handling the Grievance and information on how to submit written material. The person(s) who reviews the Grievance will not be the same person(s) who made the initial Adverse Determination. During the review, all information, documents, and other materials submitted relating to the claim will be considered, regardless of whether they were considered in making the previous claim decision. The Insured will not be allowed to attend, or have a representative attend, a First Level Review. The Insured may, however, submit written material for consideration by the reviewer(s).

When the Grievance is based in whole or in part on a medical judgment, the review will be conducted by, or in consultation with, a medical doctor with appropriate training and expertise to evaluate the matter.
Following our review of your Grievance, we must issue a written decision to you and, if applicable, to your representative or provider, within 20-days after receiving the Grievance. The written decision must include:

(1) The name(s), title(s) and professional qualifications of any person(s) participating in the First Level Review process.
(2) A statement of the reviewer's understanding of the Grievance.
(3) The specific reason(s) for the reviewer's decision in clear terms and the contractual basis or medical rationale used as the basis for the decision in sufficient detail for the Insured to respond further to our position.
(4) A reference to the evidence or documentation used as the basis for the decision.
(5) If the claim denial is based on medical necessity, experimental treatment or similar exclusion, instructions for requesting an explanation of the scientific or clinical rationale used to make the determination.
(6) A statement advising you of your right to request a Second Level Review, if applicable, and a description of the procedure and timeframes for requesting a Second Level Review.

Second Level Review

The Second Level Review process is available if you are not satisfied with the outcome of the First level Review for an Adverse Determination. Within ten business days after receiving a request for a Second Level Review, we will advise you of the following:

(1) the name, address, and telephone number of a person designated to coordinate the Grievance review for the Company;
(2) a statement of your rights, including the right to:
- attend the Second Level Review
- present his/her case to the review panel;
- submit supporting materials before and at the review meeting;
- ask questions of any member of the review panel;
- be assisted or represented by a person of his/her choice, including a provider, family member, employer representative, or attorney.
- request and receive from us free of charge, copies of all relevant documents, records and other information that is not confidential or privileged that were considered in making the Adverse Determination.

We must convene a review panel and hold a review meeting within 45-days after receiving a request for a Second Level Review. We will notify you in writing of the meeting date at least 15-days prior to the date. The review meeting will be held during regular business hours at a location reasonable accessible to you. In cases where a face-to-face meeting is not practical for geographic reasons, we will offer you the opportunity to communicate with the review panel at our expense by conference call or other appropriate technology. Your right to a full review may not be conditioned on whether or not you appear at the meeting.

If you choose to be represented by an attorney, we may also be represented by an attorney. If we choose to have an attorney present to represent our interests, we will notify you at least 15 working days in advance of the review that an attorney will be present and that you may wish to obtain legal representation of your own.

The panel must be comprised of persons who:

(1) were not previously involved in any matter giving rise to the Second Level Review;
(2) are not employees of the Company or Utilization Review Organization; and
(3) do not have a financial interest in the outcome of the review.

A person previously involved in the Grievance may appear before the panel to present information or answer questions.

All persons reviewing a Second Level Grievance involving a Utilization Review non-certification or a clinical issue will be providers who have appropriate expertise, including at least one clinical peer. If we use a clinical peer on an appeal of a Utilization Review non-certification or on a First Level Review, we may use one of our employees on the Second Level Review panel if the panel is comprised of 3 or more persons.

We must issue a written decision to you and, if applicable, to your representative or provider, within 10 business days after completing the review meeting. The decision must include:

(1) the name(s), title(s) and qualifying credentials of the members of the review panel;
(2) a statement of the review panel's understanding of the nature of the Grievance and all pertinent facts;
(3) the review panel's recommendation to the Company and the rationale behind the recommendation;
(4) a description of, or reference to, the evidence or documentation considered by the review panel in making the recommendation;
(5) in the review of a Utilization Review non-certification or other clinical matter, a written statement of the clinical rationale, including the clinical review criteria, that was used by the review panel to make the determination;
(6) the rationale for the Company's decision if it differs from the review panel's recommendation;
(7) a statement that the decision is the Company's final determination in the matter;
(8) notice of the availability of the Commissioner's office for assistance, including the telephone number and address of the Commissioner's office.

EXPEDITED REVIEW

You are eligible for an expedited review when the timeframes for an Informal, formal First Level review or Second Level review would reasonably appear to seriously jeopardize your life or health, or your ability to regain maximum function. An expedited review is also available for all Grievances concerning an admission, availability of care, continued stay or health care service for a person who has received emergency services, but who has not been discharged from a facility.

A request for an expedited review may be submitted orally or in writing. An expedited review must be evaluated by an appropriate clinical peer in the same or similar specialty as would typically manage the case being reviewed. If we don't have the information necessary to decide an appeal, we will send you notification of precisely what is required within 24-hours of our receipt of your Grievance. All necessary information, including our decision, will be transmitted by telephone, facsimile, or the most expeditious method available. Provided we have enough information to make a decision, you, your authorized representative, or a provider acting on your behalf will be notified of the determination as expeditiously as the medical condition requires, but in no event more than 72-hours after the review has commenced. Written confirmation of our decision will be provided within 2 working business days of the decision and will contain the same items described in the written decision requirements for First Level reviews.

If the expedited review does not resolve the situation, you, your representative or a provider acting on your behalf may submit a written Grievance.

We will not provide an expedited review for retrospective reviews of Adverse Determinations.

UNITED STATES FIRE INSURANCE COMPANY

Administrative Offices: 5 Christopher Way • Eatontown, NJ 07724

PARTICIPATING ORGANIZATION ENDORSEMENT

This Endorsement is attached to and made part of the Certificate as of the Certificate Effective Date. It applies only to Accidents and losses of life that occur on or after that date. It is subject to all of the provisions, limitations and exclusions of the Certificate except as they are specifically modified by this Endorsement.

1. The following definition is added to the Definitions section of the Certificate:

   Participating Organization – means an organization:
   1) Which elects to offer coverage under the Group Policy by completing a Participation Organization Application that has been accepted by the Company;
   2) Which completes a participation agreement with the Company;
   3) Which remits the required premium when due; if applicable, and
   4) While coverage through the Participating Organization is available under the Certificate.

2. The following section is added to the Certificate:

   PARTICIPATING ORGANIZATION EFFECTIVE AND TERMINATION DATES

   Effective Date. A Participating Organization's coverage under the Certificate begins on the later of: 1) Participating Organization Effective Date shown in the Participating Organization Application at 12:01AM Standard Time at the address of the Participating Organization shown in the Participating Organization Application; or 2) the Certificate Effective Date.

   Termination Date. We may terminate coverage on or after the anniversary of any premium due date. Written notice must be given at least 31 days prior to such premium due date.

   The Participating Organization may terminate the coverage on any premium due date. Failure by the Participating Organization to pay premium when due or within any applicable grace period shall be deemed notice to us to terminate coverage at the end of the period for which premium was paid.

3. The references in the Certificate to "Certificateholder," where applicable, mean "Participating Organization," respectively.

4. The following language applies to each Rider attached to the Certificate:

   Any Riders attached to the Certificate apply only with respect to Accidents and losses of life that occur on or after the later of:
   1) The effective date of each Rider; or
   2) The effective date of the Participating Organization's coverage under each Rider.

   Each Rider applies with respect to a Participating Organization's coverage under the Certificate only if the Participating Organization has elected the coverage described in each Rider, as indicated in the Participating Organization Application.

Signed for **United States Fire Insurance Company** By:

Signature	**Signature**
	
Marc J. Adee Chairman and CEO	James Kraus Secretary

When used throughout this document “The Company”, “Our”, “We”, or “Us” means:

☐ **United States Fire Insurance Company**

☐ **The North River Insurance Company**

☐ **Crum & Forster Indemnity Company**

PRIVACY POLICY AND PRACTICES

The Company values your business and your trust. In order to administer insurance policies and provide you with effective customer service, we must collect certain information about our customers. We want you to know that we are committed to protecting your private information and we will comply with all federal and state privacy laws. Below is a Privacy Notice describing our policy regarding the collection and disclosure of personal information. Please review this Notice and keep a copy of it with your records.

Your Privacy is Our Concern

When you apply to The Company for insurance or make a claim against a policy written by The Company, you disclose information about yourself to us. There are legal requirements governing the collection, use, and disclosure of such information. The Company maintains physical, electronic, and procedural safeguards that comply with state and federal regulations to guard your personal information. We also limit employee access to personally identifiable information to those with a business reason for knowing such information. The Company instructs our employees as to the importance of the confidentiality of personal information, and takes measures to enforce employee privacy responsibilities.

What kind of information do we collect about you and from whom?

We obtain most of our information from you. The application or claim form you complete, as well as any additional information you provide, generally gives us most of the information we need to know. Sometimes we may contact you by phone or mail to obtain additional information. We may use information about you from other transactions with us, our affiliates, or others. Depending on the nature of your insurance transaction, we may need additional information about you or other individuals proposed for coverage. We may obtain the additional information we need from third parties, such as other insurance companies or agents, government agencies, medical personnel, the state motor vehicle department, information clearinghouses, credit reporting agencies, courts, or public records. A report from a consumer reporting agency may contain information as to creditworthiness, credit standing, credit capacity, character, general reputation, hobbies, occupation, personal characteristics, or mode of living.

What do we do with the information collected about you?

If coverage is declined or the charge for coverage is increased because of information contained in a consumer report we obtained, we will inform you, as required by state law or the federal Fair Credit Reporting Act. We will also give you the name and address of the consumer reporting agency making the report. We may retain information about our former customers and may disclose that information to affiliates and non-affiliates only as described in this notice.

To whom do we disclose information about you?

We may disclose all the information that we collect about you, as described above. We may disclose such information about you to our affiliated companies, such as:

- Insurance companies;
- Insurance agencies;
- Third party administrators;
- Medical bill review companies; and
- Reinsurance companies.

We may also disclose nonpublic personal information about you to affiliated and nonaffiliated third parties as permitted by law. You have a right to access and correct the personal information we collect, maintain, and disclose about you.

How to contact Us

You may obtain a more detailed description of the information practices prescribed by law by contacting us at the address below. Remember to include your name, address, policy number, and daytime phone number.

Privacy Policy Coordinator
Fairmont Speciality
5 Christopher Way, 3rd Floor
Eatontown, New Jersey 07724

APPLICATION

is made to

UNITED STATES FIRE INSURANCE COMPANY

Administrative Office: 5 Christopher Way, Eatontown, NJ 07724

Policy Number: US963842

Policyholder: San Pedro Property Owner Alliance

Address: San Pedro Property Owner Alliance
390 W 7th Street
San Pedro, CA 90731

The Policyholder hereby applies to United States Fire Insurance Company for the group special risk coverage provided by the Policy as described in the Attachment No. 1. The Policyholder approves and accepts the Policy by the signature shown below. The Policy takes effect on the date specified on the face page of the Policy.

DATED AT: San Pedro, CA

on: Sep 15, 2017

SIGNED FOR THE POLICYHOLDER:

By: __On File_____
(Signature and Title)

Agent's Name: _____
(Must be a Resident Licensed Agent where required by law)

ATTACHMENT # 1

San Pedro Property Owner Alliance

Requested Effective Date: Sep 15, 2017

1) Event Name and Location:

Dia de los Muertos
6th Street between Pacific Avenue and Centre Street
390 W. 7th Street
San Pedro, CA 90731

Event Date: Oct 29, 2017 - Oct 30, 2017
Class and Option: Class 1, Option 1

Rate: 8.00 % of primary GL premium (no minimum premium)
Premium: $68.00